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ABSTRACT

The paper summarized the rationale for early intervention programs and describes the major components of the Project WISP (Wyoming Infant Stimulation Program) center-based program for handicapped young children (18-36 months). Early intervention for handicapped children is justified from five points-of-view: prevention of failure during subsequent school years, parent programming, learning, social change, and educational economics. It is explained that Project WISP was established to provide demonstration/replication services to interested individuals throughout Wyoming and to directly serve young handicapped children and their families. Five major components of the model are outlined: screening, instructional development, instruction, and evaluation. Appended are a sample intake form, an excerpt from the Developmental Screening Inventory, an excerpt from the WISP information manual, and an excerpt from SEED (Sewall Early Education Development Program) Developmental Profiles. (SBH)

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Special Education and Related Services for
Handicapped Young Children (18 - 36 months):
The Project WISP Center-Based Program

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Introduction

Early intervention (e.g., special education and related services such as speech pathology) for handicapped children may be justified from at least the following five points-of-view:

1. Prevention of failure during subsequent school years. Data obtained from First Chance Network projects (Jordan, Hayden, Karnes & Wood, 1977) and Head Start programs (Haring, 1978) indicate that "graduates" of early education programs for the handicapped tend to require less intensive special education and related services during subsequent school years.

2. Parent programming. It is a "given" (Jordan, et al., 1977) that parents/families are also served in programs for young handicapped children. Parents are recipients of a variety of training programs including those stressing direct instructional techniques (Stile & Atkinson, 1976) and advocacy. In addition, parents are given the opportunity to "ventilate" and respite care is provided.

3. Learning. From a learning perspective, children have obtained 80 percent of their total adult intellectual capacity by eight years of age (Roos, 1974). Other arguments supporting early education of handicapped children from a learning point-of-view are that (a) learning is more rapid and facile in early years, (b) it is easier to learn a new behavior than to stamp out one set and replace it with another, and (c) the earlier a child starts school, the more skills he or she will have upon leaving school.

4. Social change. Associated with a growing number of teen-aged mothers is a growing number of "high-risk" births (Forbes, 1958). Additionally, medical advances have made possible the survival of an increasingly high proportion of premature infants for whom the risk of central nervous system and visual handicaps is great (Meier, 1973).

5. Educational economics. Early education of handicapped children is also supported from an economics point-of-view. As Frohreich (1973) has described it, special education is more expensive than the regular variety due to (among other reasons) the necessity for a higher teacher/student ratio. Thus, if the need for special education and related services is minimized through early intervention, "excess costs" may be reduced significantly.

Project WISP was established to (a) provide demonstration/replication services (e.g., inservice training) to interested individuals throughout Wyoming and (b) directly

serve handicapped young children (0 - 36 months) and their families. The current paper describes the ongoing center-based program (18 - 36 months) which is located in Laramie, Wyoming. This program is an HCEEP First Chance Demonstration Project which is funded by the Bureau of Education for the Handicapped, USOE.

The WISP Model

The five major components of the WISP model may be described graphically as in Figure 1. These components are described in narrative form in separate sub-sections below. Project WISP parents are actively involved in all major program components except assessment (i. e., screening, instructional development, instruction and evaluation).

Insert Figure 1 about here

Screening

Each child who has been referred to the program is screened to detect possible developmental delays and to determine appropriate placement. The parents are interviewed and information regarding birth history, developmental milestones, health record, social behavior and parental needs is recorded on the WISP intake form (Appendix A). The Developmental Screening Inventory (DSI) (Knoblock & Pasamanick, 1974) is administered by the teacher and aide to estimate the child's level of development in the following five areas: (a) adaptive, (b) gross motor, (c) fine motor, (d) language and (e) personal-social (Appendix B). The child is eligible for the center-based program if administration of the DSI indicates a developmental delay of at least three months and/or if a contributing factor such as osteogenesis or child abuse is present. Parents of children admitted to the program are provided with additional program information (Appendix C) and alternatives are discussed for children for whom the center-based program is found inappropriate.

Assessment

When a child enters the center-based program, the Sewall Early Education Developmental Program (SEED) (Herst, Wolfe, Jorgensen & Pallan, 1972) is administered by the teacher, aide and related service personnel to determine strengths and weaknesses in the following eight areas of development: (a) fine motor, (b) gross motor, (c) social-

emotional, (d) adaptive reasoning, (e) receptive language, (f) expressive language, (g) feeding and (h) dressing/simple hygiene (Appendix D).

Instructional Development

Assessment data are presented at a staff-parent meeting where recommendations are made for individualized programming. Parents are encouraged at this time to express their desires regarding broad areas of emphasis (e.g., self-help) and/or specific skills and behaviors to be included. Long-range goals and short-term objectives are then specified and each objective is task analyzed. Goals, objectives and steps in instructional sequences are placed on clipboards for each child and these clipboards are kept in the classroom for use during direct instruction and data collection.

The following list contains sources used in the development of individualized curricula:

1. Isn't it time he outgrew this? (Baldwin, Fredericks and Brodsky, 1976)
2. Learning Accomplishment Profile (Chapel Hill Training Outreach Project, 1976)
3. Performance Objectives for Preschoolers (Adapt Press, 1976)
4. The Portage Program (Shearer, et al., 1976)
5. The teaching research infant and child center curriculum for the moderately and severely handicapped (Fredericks, et al., 1975)

Instruction

The center-based program combines traditional preschool stimulation activities (e.g., water play, "Simon Says") with structured direct instruction. The stimulation activities and direct instruction are both geared to facilitate learning in skills and behaviors specified at the instructional development stage.

Staff members include the classroom teacher, aide, physical therapist and speech therapist. The teacher plans, conducts and supervises stimulation activities and direct instruction. The aide assists in planning and conducting stimulation activities and direct instruction. The physical therapist and speech therapist, whose services are shared with a program for older handicapped preschoolers, provide necessary related services. Volunteers, parents and practicum students are trained to assist the professional staff and to interact appropriately with the children. All staff members are trained to

teach skills and behaviors in small steps. All staff members receive training in behavior management and data collection techniques. As a trainer conducts each program, he or she records data regarding the child's performance.

Evaluation

Continuous monitoring and probes (Jordan, et al., 1977) are combined for program evaluation purposes. Data are recorded continuously to enable the staff to track the child's progress on a daily basis and to make immediate program adjustments. Probes are conducted every three months. At these intervals, the child's progress is noted in relation to goals and objectives specified earlier in the program and staff members meet with parents to determine necessary curriculum changes.

Parent Involvement

Parents are encouraged to observe the center-based program as often as possible and/or to more actively participate in its various components (e.g., to act as a member of the teaching staff). Parents who so participate acquire teaching and management skills which may be used at home. In addition, specific speech and physical therapy techniques are provided at the center by the related service personnel.

Home visits are made on a weekly basis by the classroom teacher. During these visits the teacher shares information (e.g., program progress) and suggests activities that will reinforce classroom learning.

Conclusion

This paper summarized the rationale for early intervention programs and described the major components of the Project WISP center-based program for handicapped young children (18 - 36 months). Further information may be obtained from Janis Jelinek, Project Director, and Thom Flamboe, Project Coordinator, Box 3224, University Station, Laramie, Wyoming, 82071.

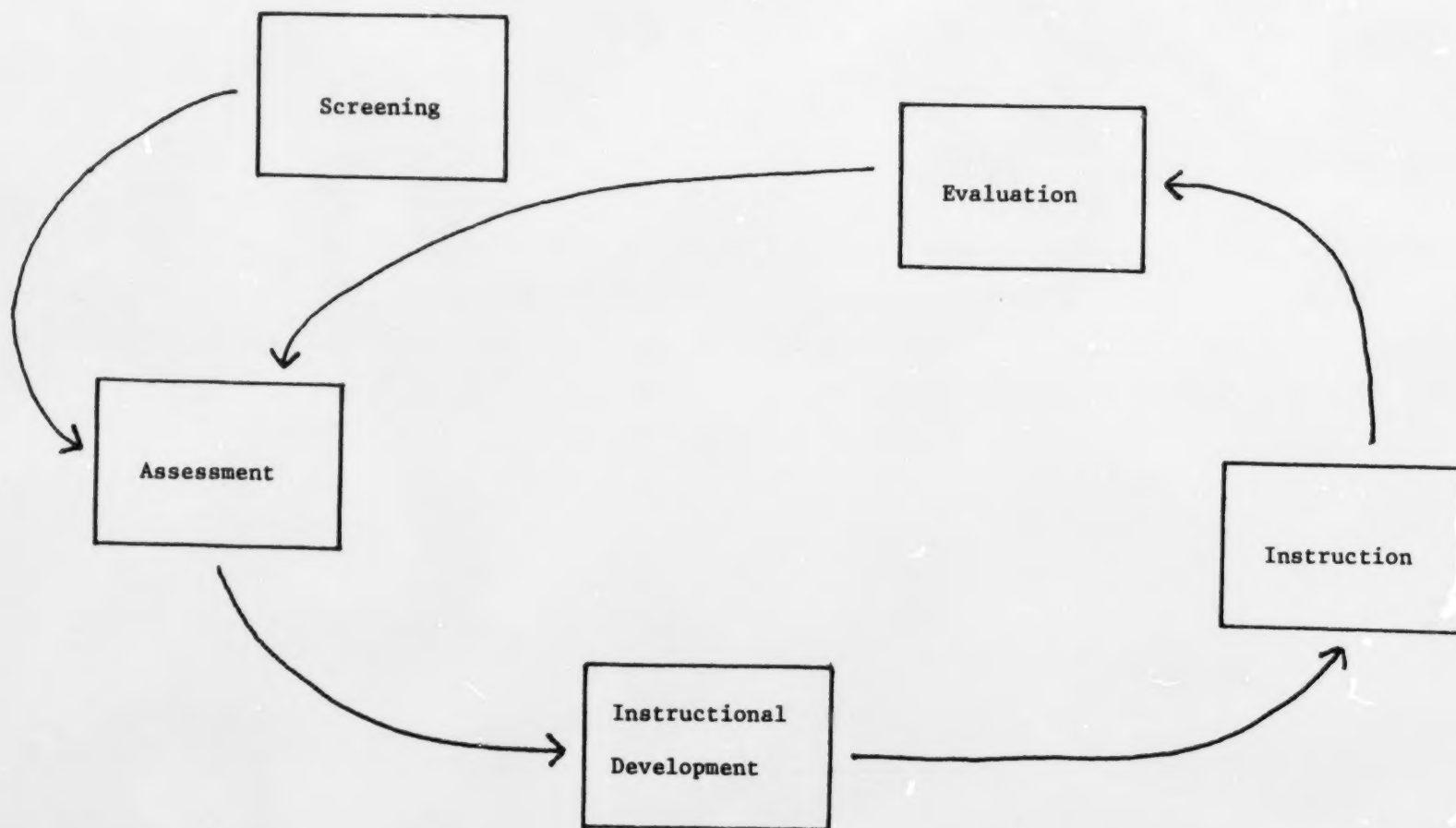


Figure 1. Five major components of the Project WISP model.

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Appendix A
Intake Form

PARENT INTAKE INTERVIEW

Child's Name _____

Child referred by: _____

Date: _____

Address: _____

Interviewer: _____

Telephone: _____

Child's Birthdate: _____

Age at time of interview: _____

Mother's Name: _____

Where Employed: _____

Business Telephone: _____

Father's Name: _____

Where Employed: _____

Business Telephone: _____

Emergency number if parents cannot be reached: _____

Baby Sitter's Name _____

Baby Sitter's Telephone: _____

Child's Doctor: _____

Telephone: _____

Siblings (name, age, sex):

Any transportation needs?: _____

Medical History:

1. Has your child been immunized? _____

2. Are immunizations up to date? _____

3. Vision tested? _____

4. Hearing tested? _____

5. Other tests? _____

6. Has your child ever been hospitalized? If yes, where and when? _____

7. Is your child presently on any medication? _____

8. Does your child have any allergies? _____

9. How often is your child ill, with what? _____
10. What is your child's present state of health? _____

Prenatal History

1. Did you receive prenatal care during your pregnancy? If yes, of what nature?

2. How many pregnancies have you had? Live born, miscarriages, and still births?

3. Describe your health during your pregnancy. Any unusual conditions?

4. Were there any unusual conditions during the birth of your child, such as prolonged labor, presentation of delivery, premature delivery, anoxia, etc?

Neo-natal History

1. What was the length and weight of your baby at birth? _____

2. Did your child require any special care, such as oxygen, transfusion, incubator, or extended stay?

Developmental Milestones:

1. Age your child rolled from front to back? _____
2. Age your child sat? _____
3. Age your child crawled? _____
4. Age your child walked? _____
5. Age your child said his first word? _____

6. Age your child was potty trained? _____

Questions concerning your child's development

1. Any feeding problems such as, difficult to feed, excessively hungry, colic, etc.? _____

2. Was the child breast or bottle fed, from what does he presently drink? _____

3. When did your child begin to eat solid foods, was this an easy adjustment? _____

4. What kinds of foods make up your child's daily diet? _____

5. Describe your child's appetite, what are his likes and dislikes? _____

6. Describe your child's speech, how many words or word combinations? _____

7. Does your child respond to his name? _____

8. Will your child follow a simple direction? _____

9. By what means does your child move about the house? _____

10. Does your child bump into objects or take frequent falls? _____

11. Does your child dry his hands and face independently? _____

12. Does he brush his teeth? _____

13. Has toilet training been started, if yes, what is the procedure? _____

14. Is your child toilet trained? _____

15. Describe how your child plays with other children. _____

16. Does your child like toys; what are his favorites? _____

17. Describe your child's sleep pattern; does he go to sleep easily; sleep through the night; nap? _____

18. Where does your child sleep? _____
19. Does your child separate from you easily? _____
20. Is your child afraid of strangers? _____
21. Does your child get along with playmates, siblings, etc.? _____
22. Does your child have any fears, if yes, what are they? _____

Parents

1. What do you think are your child's strengths? _____

2. What do you think are your child's weaknesses? _____

3. What goals do you have for your child? _____

Appendix B
Excerpt from DSI

A DEVELOPMENTAL SCREENING INVENTORY

From 4 Weeks
to
18 Months



by

HILDA KNOBLOCH, M.D.
BENJAMIN PASAMANICK, M.D.
EARL S. SHERARD, JR., M.D.

based on the work of Arnold L. Gesell & Catherine S. Amatruda

GENERAL INSTRUCTIONS FOR USE OF THE D.S.I.

Development proceeds in an orderly predictable manner, with the same variability in behavior for normal infants found in all biologic measurements. By asking some questions of parents, observing the infant's behavior and recording this information systematically, an estimate of the level of function in various areas of behavior can be made which correlates very highly with the maturity age assigned on the basis of a complete Gesell Developmental and Neurologic Examination, from which the items are adapted.

This screening inventory will be of value for serial observations in well-baby supervision as well as for diagnostic problems referred for evaluation. **READ THE ENTIRE INVENTORY BEFORE ATTEMPTING TO USE IT.**

DO NOT BE ALARMED BY THE LARGE NUMBER OF QUESTIONS. They cover the age range from 1 to 18 months and any *one* infant can *usually* be evaluated by 2 or 3 consecutive age levels at most. We have tried to phrase the items as clearly as possible; specific explanations for some are listed in the instructions. It will help to understand them if you *look at the adjacent age levels*, e.g., *lift vs. hold* at 8 and 12 weeks in Gross Motor Behavior; offer the parents both alternatives. **ASK THE QUESTIONS AS THEY ARE STATED.**

START by asking questions appropriate to the chronologic age of the child. If the answers are negative, drop to a

lower age level; then work back up. It is best to cover **ONE AREA OF BEHAVIOR AT A TIME** rather than one age level at a time. *Remember that the infant may be slow in one area and normal in other areas.* Keep asking questions above the child's chronologic age until no more positive answers are obtained. When you start your interview **TELL THE PARENTS SOME QUESTIONS ASKED WILL BE ABOVE THE CHILD'S LEVEL OF ABILITIES.**

Record the parents' answers [H — History Col.] and your observations [O — Observed Col.] on each visit, to the left of each item. For behavior which depends on your observations only, the history column is blocked out. Record responses + [Present], — [Absent], or X [Unknown]. If an infant is seen every 4 weeks there may be some overlap in behavior; confusion can be avoided by recording in different colors. Failure to progress normally will be obvious if significant overlap between visits persists.

Blocks are provided at the upper left and lower right of the form for recording the age level at which the child is functioning and the diagnoses. In each of the five areas of behavior, assign maturity levels in weeks, or months, based on your clinical judgment of the age levels your recorded history and observations describe best. You can interpolate between the adjacent age columns, e.g., 35 weeks, since a 32 week infant adds 36 weeks behavior gradually over the next 4 weeks. **DO NOT FORGET TO TAKE THE PARENTS'**

From the DIVISION OF CHILD DEVELOPMENT of the Department of Pediatrics,
and the Department of Psychiatry, The Ohio State University College of Medicine,
and The Children's Hospital, Columbus, Ohio

KEY AGE

28 WEEKS SUPPORTED SITTING ONE HAND APPROACH & GRASP

24 Weeks

32 Weeks

H	O		H	O		H	O	
		Reach and pick up or take toy with both hands			Reach and pick up or take toy with one hand only			Pick up one small toy and then second one
		Reach for toy dropped within reach			Transfer toy easily, hand to hand			Hold these two prolongedly
		Put toy in mouth when held supported in sitting			Bang toy up and down when sitting supported			Secure toy by string if string contacted by hand
		Grasp foot when lying on back (in supine)			Lift head from bed if on back			Sit 1 minute erect unsteady on hard surface
		Roll to abdomen, get both arms out from under chest			Sit if put on hard surface leaning on hands			Stand, hands held shoulder height
					Stand if chest held under arms			Pivot in circle, prone, using arms
		Pick up small toy and hold in center of palm with all fingers			Pick up small toy, hold to radial side palm with 2nd and 3rd finger			Try to pick up crumb by raking with thumb, 2nd and 3rd fingers, usually little arm movement
					Put whole hand on crumb, rake it			
		Grunt and growl (deep sounds)			Say "Mum-mum-mum" especially crying			Make single consonant sounds, "da, ba, ga, ka"
		Initiate "conversation" with toys or people			Make some vowel sound in series: "ah-ah-ah, uh-uh-uh, ah-ah-ah"			
		Knew strangers from family			Feet to mouth when lying on back			Bite and chew toys, not just lick
		Smile and talk to self if put close to mirror			Reach out and put self if put close to mirror			Persist in reaching for toys out of reach

H = HISTORY

O = OBSERVATION

DIAGNOSTIC CATEGORIES:

N = Normal or Advanced

Q = Questionable

A = Abnormal



15 Months
Builds Tower of Two

15 Months

KEY AGE

18 MONTHS LOOKS SELECTIVELY AT AND IDENTIFIES PICTURES



18 Months
Scribbles Spontaneously

H	O		H	O		DATE
		File 1 small toy on 2nd (tower 2)			Dump crumb out of bottle—may show	AGE
		Get 5-6 (of 10) small toys in cup or box; doesn't put all 10 in			Scribble when you hand him crayon, i.e., spontaneously	MATURITY LEVEL
		Stroke crayon in air imitatively after you draw vertical stroke			Imitate stroke on paper after you draw vertical stroke	DIAGNOSIS
		No longer creep or crawl			Run stiff-legged	MATURITY LEVEL
		Get up in middle of floor and walk alone			Rarely fall when walking	DIAGNOSIS
		Collapse and catch self when falls			Climb into adult chair	MATURITY LEVEL
					Walk upstairs if you hold one hand	DIAGNOSIS
		Drop crumb into bottle just if you point and ask him to			Turn pages of book 2-3 at once	MATURITY LEVEL
		Help turn pages of book			Stack up 3 small toys (tower 3)	DIAGNOSIS
		4-6 words, including first names			Point to picture, if ask: dog, baby	MATURITY LEVEL
		"Talk" foreign language—jargon			Look back and forth as you point from 1 picture to other in book	DIAGNOSIS
		Put at pictures in book				MATURITY LEVEL
		Indicate wants by pointing or vocalizing (grunt, "uh-uh-uh")			Walk or crawl, pulling string toy	DIAGNOSIS
		When fed leaves dish on tray			Hug and love doll, stuffed animal	MATURITY LEVEL
					Use spoon to feed, spill good bit	DIAGNOSIS

Appendix C
Excerpt from WISP Information Manual

**The
Wyoming
Infant
Stimulation
Program**

**Welcomes
You**

Transportation

If you are unable to bring your child to the Center, transportation can often be provided. -

If your child is usually picked up by the Center bus or car please be sure to telephone the Center if the child should not be picked up.

Clothing

All of your child's clothes should be labeled. Please bring diapers and any other clothes he will need in a sack or other type of bag. Also, please send a plastic bag each day for wet clothes or diapers.

Weather

The Center follows the public schools in closing in bad weather. If there is a bad snow or ice storm, listen to your radio reports. If the public schools are closed, the Center will be closed, too.

Holiday schedule

The Center observes the same holiday schedule as the Public Schools. Parent-Teacher Conferences will be announced ahead of time so that you can arrange your schedule accordingly.

Appendix D
Excerpt from SEED

SEED
DEVELOPMENTAL PROFILES

Developed by:

Joan Herst, M.S., Special Education Coordinator
Sheila Wolfe, O.T.R.
Gloria Jorgensen, R.P.T.
Sandra Pallan, M.A., Language & Speech Pathologist, CCC-SP

SEWALL EARLY EDUCATION DEVELOPMENTAL PROGRAM

Diana Neel Pefley, M.S.W., Project Director

Sewall Rehabilitation Center -- Denver, Colorado

Supported by:

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SEED DRESSING AND SIMPLE HYGIENE DEVELOPMENTAL PROFILE

لے

Read Introductions before administering

Check for these as well as 100% - to school
SEED DRESSING AND SIMPLE HYGIENE DEVELOPMENTAL PROFILE

Page 3 of 3

includes a pants

DESCRIPTION	15 Months (1.25 yr)	18 Months (1.5 yr)	21 Months (1.75 yr)	24 Months (2 yr)	30 Months (2.5 yr)	36 Months (3 yr)	42 Months (3.5 yr)	48 Months (4 yr)
Dressing Behaviors	helps put arms and legs into sleeves and pants	takes off simple article of clothing (hat, socks, mittens) tries to put on shoes tries to take off unlaced shoes	tries to take off unfastened coat	puts on simple article of clothing (sock, mittens, hat) takes off unlaced shoes finds arm holes and puts arms in helps push down pants helps pull up pants helps unzip zipper takes off unfastened coat	tries to undress self takes off pants	puts on shoes (not necessarily correctly) unbuttons large front and side buttons tries to lace shoes; fails tries to dress self	begins to button large buttons helps take off pullover shirt	undresses with minimal supervision dresses with minimal supervision laces shoes tries to imitate tying shoes begins to distinguish front and back of clothes
Simple Hygiene Behaviors		tries to wash hands and/or face	begins to help dry face and/or hands	begins to use soap to wash helps to wash hands and face helps to dry hands and face	helps while being bathed	begins to help blow nose tries to comb hair	washes and dries hands washes and dries face	washes and dries face and hands brushes teeth with or without supervision

The Following Categories are in 3 Month Intervals

The Following Categories are in 6 Month Intervals